

Division of Medicaid

APR-DRG (Inpatient) Quick Tips

Effective October 1, 2013

KEY CONTACTS:

- Medicaid website: www.medicaid.ms.gov.
- For Xerox Provider and Beneficiary Services assistance call 1-800-884-3222
- The main website for APR-DRG inpatient pricing information is:
<https://www.medicaid.ms.gov/HospitalInpatientAPR-DRGPayment.aspx>
This site contains:
 - Training materials
 - FAQ
 - DRG pricing calculator
 - Other helpful information
- A list of APR-DRG codes is located on the 3rd tab ("DRG table") of the DRG pricing calculator.

KEY POINTS to CONSIDER:

1. All claims must contain a gender code; otherwise the claim will be suspended.
2. Payments for medical education will be made on the claim, as a flat amount per stay. Medical education payments will not be made to out-of-state hospitals.
3. Outpatient services within three (3) days prior to the admission date that are considered to be part of the inpatient stay will not be paid separately. As with Medicare payment methodology, hospitals may indicate that outpatient services are unrelated to the inpatient stay through the appropriate use of condition code 51 on the outpatient claim. Please take care not to bill Medicaid or the Medicaid managed care plans for outpatient services that are defined to be within the window.
4. Interim claims (bill types 112 and 113) are not required but may be submitted if the stay exceeds 30 days. Hospitals should ensure proper use of the correct discharge status code when an interim claim is filed. When a patient is discharged, the interim claims should be voided or adjusted and the hospital should submit a single claim for the entire stay.
5. All newborns should be billed on their own claim, not on their mother's claim.
6. Mississippi Medicaid no longer has annual service limits (e.g., 30 days of inpatient care per year). If the patient meets existing criteria for medically necessary care, appropriate care will be reimbursed.
7. Claims with frequency codes 4 (last interim claim) and 5 (late charge) will be denied. Use frequency codes 1 (admit thru discharge) and 6 (adjustment) as appropriate.
8. Treatment Authorization Number (TAN):
 - Stays that exceed 19 days require continued stay review.
 - The TAN begin date must equal the admit date.
 - Hospitals should contact HSM for a TAN on a NEWBORN only if the length of stay will exceed six (6) days (including the discharge date).
9. Hospitals do not need to buy APR-DRG software and need not show the APR-DRG on the claim. The APR-DRG is assigned by the Medicaid claims processing system based on the diagnoses, procedures and other information submitted by the hospital. Designating the APR-DRG on the claim is not necessary.
10. Hospitals are required to submit valid values for the Present on Admission (POA) indicator.
11. MSCAN beneficiaries:
 - Providers do not need to submit inpatient claims to the Coordinated Care Organizations (CCOs) for denial prior to submitting to the MS DOM. This is currently the number two denial edit for hospital inpatient claims.